Implementing Integrated Family Planning and HIV/AIDS Policies and Programs: Tools and Resources[1]

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I. Introduction

Why integrate Family Planning into HIV services?

With the pressing needs related to the HIV/AIDS pandemic, is there any need to devote resources to supporting the provision of family planning (FP)? Given the strong links between HIV/AID and FP, the answer is an emphatic yes. The same unprotected sexual act can lead to unintended pregnancy and HIV infections. Given that an estimated 80 percent of HIV cases are transmitted sexually and an additional 10 percent are transmitted from mothers to children perinatally or during breastfeeding, linking HIV and reproductive health (RH) programs is crucial (Askew and Berer, 2003). Women and men have a need for both protection against pregnancy and protection against HIV and other sexually transmitted infections (STIs). However, programs to prevent unintended pregnancy and to prevent infection have typically been separate. This reliance on separate programs is beginning to change. The International Conference on Population and Development (ICPD) held in Cairo in 1994 called for a holistic approach to meeting women's and men's RH needs throughout their lives, from childhood, through adolescence and adulthood. ICPD called for integrated services to meet these needs, including to help individuals and couples meet their reproductive intentions and prevent disease. Cairo + 5, held 5 years after the 1994 ICPD, reiterated the call for integration.

Most efforts to date have focused on integrating HIV prevention and care into FP services (Askew and Berer, 2003). However, now the focus is shifting to integrating FP into HIV prevention, care, and treatment services, including in countries such as Kenya, Uganda, and Jamaica. Other countries, including Cambodia and Zambia, perceive a clear need to integrate services (see the country resource section for more information).

Early integration efforts focused on integrating HIV prevention messages into FP and efforts to screen and treat sexually transmitted infections (STIs) in a variety of RH care settings. More recently, attention has shifted to voluntary counseling and testing (VCT) and preventing mother-to-child transmission (PMTCT) services as entry points for providing information on pregnancy prevention and contraceptive services. As more women and men begin antiretroviral therapy (ART), there is a pressing need to integrate FP into treatment programs. As antiretrovirals (ARVs) are becoming more widely available around the world, it is important to include FP as a part of treatment activities.

[1] This toolkit is designed to look specifically at incorporating family planning into HIV care and treatment services. While important, the integration of HIV services into family planning and reproductive health programs and the integration of family planning into counseling and testing services (C&T) are outside the scope of this project.

- ✓ *VCT provides an opportunity to affect sexual and fertility behavior.* Counseling can affect behavior change through improved decision making. Armed with information, individuals and couples have a greater ability to reduce their risk for infections, and are better prepared to achieve their fertility goals through choosing appropriate contraceptive methods.

- ✓ *Reducing unintended pregnancies is a key component of strategies to prevent maternal to child transmission of HIV (PMTCT).* All women have the right to decide whether, when, and how many children to have. However, providing FP counseling to HIV-positive women is often not a priority. It is vital that HIV-positive women understand the risks of vertical transmission and have the knowledge and skills to make decisions regarding future pregnancies.

- ✓ *Women and men often start ARV treatment when they have many years remaining in their reproductive lives*. People on ARV face reproductive decisions and need the information and means to have children or avoid childbearing, depending on their choice. In addition, initiation of ARV treatment will also, in many cases, result in improved health, which may lead to the resumption of sexual activity. Treatment with ARVs involves regular contact with health care providers. The contacts represent opportunities to discuss reproductive intentions and to provide contraceptive information and services.

Integration offers an opportunity to improve health care services. Integration at the program level offers the opportunity to provide a broader spectrum of services to people in need. The promotion of integration has been intended to ensure greater responsiveness to client needs and to enhance the efficiency and effectiveness of service delivery, including by reducing costs. At the same time, integration poses many challenges.

Why integrate at the policy level?

> *Specifying integration in policies makes it more likely that integration will occur at the service delivery level*

National policies, such as RH and HIV/AIDS policies, provide the vision and framework for the action of governments, and set forth the goals and objectives and the involvement of various groups. By explicitly codifying the place that FP can and should play in national HIV programs, national policies increase the chance that integration will take place in practice. Policies provide roadmaps for programs. Therefore, if integration is not addressed at the national and operational policy levels, it is unlikely that FP and HIV programs will be integrated at the service level.

National policies provide the leadership and guidance for programs. To ensure success, national policies must be translated into programs to achieve the goals set forth at the

national level. Operational policies, described in more detail below, link national laws and policies to programs.

Results from a study of the feasibility of integration in Jamaica showed that "confusion regarding who is accountable for making policy decisions (and which operational areas to address) impedes the establishment of systemic changes needed to institutionalize integration in Jamaica" (Hardee et al., 2005) In that country and others, managers, providers, and other health officials need to work collaboratively and open a policy dialogue, thereby making it possible to scale-up FP and mother and child health (MCH) and STI/HIV/AIDS integration from pilot sites to a nationwide model.

A study in Uganda found that implementation of integrated services remains a challenge. Under Uganda's public health care system, FP and HIV/AIDS are under different reporting and authority structures in the Ministry of Health. Under the current structure, FP inputs into HIV sites are the responsibility of the Reproductive Health Division with no responsibility of the HIV/AIDS program. Because these two units are not coordinated, stock-outs of FP commodities are common in HIV sites (Asimwe et al., 2005).

Why has this CD been produced?

This CD contains tools and resources that can be used for policy development and policy implementation to integrate FP into HIV policies and programs. The seven sections are listed below:

1. International conventions (FP and HIV-related service integration)
2. National HIV policies and FP
3. VCT policies and FP
4. PMTCT policies and FP
5. ART policies and FP
6. Operational policies
7. Additional resources

Each section contains a series of resources (either full papers or links to online sources). These have been selected on the basis of pertinence to the topic at hand, inclusion of current information, and in order to ensure a broad representation for the different issues that may arise during the design or analysis of an integrated FP/HIV policy.

II. Family Planning and HIV Integration in Recent International Agreements

In addition to the 1994 ICPD *Programme of Action* and Cairo +10 update, several recent international agreements recognize the importance of integrating FP to HIV services. These include the following:

- New York Call to Commitment, 2004
- Glion Call to Action, 2004

These agreements (signed by ministers, parliamentarians, ambassadors, leaders of the United Nations (UN) and other multilateral organizations, donor organization officials, community and NGO leaders, young people, and people living with HIV) reiterate the importance of including FP in HIV services and serve as proof of the international community's commitment to integration. The creation of these documents provides a context in which to place national and operational integration policies, recognizing as they do the important role that integration can play in expanding access to FP and to reaching public health goals worldwide.

These documents recognize that both sexual and RH initiatives and HIV/AIDS initiatives must reinforce each other and that stronger linkages between the programs will result in more relevant and cost-effective programs with greater impact [United Nations Population Fund (UNFPA), page 1].

United Nations Population Fund , The Joint United Nations Programme on HIV/AIDS, and Family Care International. 2004. The New York Call to Commitment.

UNFPA and The Joint United Nations Programme on HIV/AIDS (UNAIDS), in collaboration with Family Care International convened a consultation on the AIDS epidemic in New York on June 7, 2004. Participants, including ministers, parliamentarians, ambassadors, leaders of the UN and other multilateral organizations, donor organization officials, community and nongovernmental organization (NGO) leaders, young people and people living with HIV made a call to commitment which included emphasis on the linkages between sexual and RH and HIV, and called for the promotion of programs which recognize and reaffirm these linkages.

United Nations. 2004. "The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children."

UN agencies have initiated a series of consultations to identify ways to build and reinforce linkages between RH programs and HIV/AIDS prevention and care. The first consultation took place in May 2004 and focused on the linkage between FP and MTCT. It produced the Glion Call to Action, which includes recommendations in the following areas:

- Policy and advocacy
- Program development
- Resource mobilization
- Monitoring and evaluation and research

III. Family Planning and HIV Integration in National Policies

National policies are crucial to HIV/AIDS and FP efforts. They identify national priorities, and provide the framework that guides the development of operational policies, that facilitate translation of national goals into local services (see Section IV for a definition and discussion of operational policies).

Health policies cannot guarantee implementation of services, but their existence can provide a vision for health care. Historically, components of health care have been treated separately in policies, as has been the case with FP and HIV/AIDS. Post-ICPD, countries were encouraged to enact RH policies; most mentioned the need to address HIV/AIDS as part of RH. At the same time, HIV/AIDS policies were being developed independently; with no mention of FP (Strachan et al., 2004).

In order to develop policies that address integration, it is important that representatives from both FP and HIV/AIDS programs are present. At the national level, the importance of FP needs to be addressed in national HIV/AIDS, VCT, PMTCT, and ART policies. As VCT, PMTCT, and ART policies and programs are developed, the integration of FP with these services needs to be approved by all relevant parties, including high level policy makers, ministry leaders and donors. Policymakers need to speak out frequently in support of both FP and HIV/AIDS prevention. Furthermore, it is critical that ministries of RH and HIV/AIDS/STIs divisions collaborate to develop policies that adequately address FP and HIV prevention and care and stress that the overarching goal of all of these programs is improved health and meeting client needs.

A well-designed policy for FP/HIV integration should include the *rationale* for the policy, as well as its *goals* and *objectives*. It should also include *program measures* and *indicators of success*, and a plan for *monitoring and evaluation*. *Implementation* and other *institutional arrangements* should be clearly addressed in the policy, and the *funding* and other *resources* which will allow for this implementation should be determined while in the policy design phase. One method of achieving this goal is the Policy Circle, which can be used as an organizing framework for assessing the need for integration and the resultant policy process and policy implementation (Hardee et al., 2004).

In order to develop good national policies, policy makers should examine the current policy situation and the feasibility (both financial and political) of their proposed policy. They should also ensure that it does not leave gaps that can lead to a lack of clarity and result in implementation problems. Thinking through the following questions will help to ensure that the policy is a well thought out and comprehensive approach to integrating FP with HIV service.

- ✓ Does the country have a national HIV policy? Does the policy address integration of FP?
- ✓ Are the integration-related goals of the policy clear?

✓ What level of integration is proposed? Will HIV service sites provide referrals to FP services or directly provide counseling and contraceptives?
✓ Does the policy address what groups will be targeted with integrated services?
✓ Do separate logistics streams exist for contraceptives if FP is offered at HIV services?
✓ If contraceptives are being provided, can method choice be maintained? Will people at HIV service sites be able to provide all methods?
✓ Have cost and feasibility calculations been performed for the proposed integrated programs?
✓ Are monitoring and evaluation plans in place for integrated programs that reflect the goals and indicators in the policies?

Policies that address FP and HIV/AIDS integration policies will do the following:

- Clearly address the importance of FP in HIV prevention and mitigation
- Establish clear goals for infections averted, lowering unmet need among positive women and men, etc.
- Specify exactly how FP should be addressed in HIV activities
- Include underserved groups
- Specify funding sources, including donor, government and others
- Link well defined indicators to goals
- Have a monitoring and evaluation plan

For example, Uganda's draft guidelines on HIV counseling and testing identify FP as part of a comprehensive HIV care package. India's guidelines on ART use describe the components of FP counseling in an ART program. These policies clearly recognize the importance of FP as part of HIV services, and articulate the form which it should take.

The following resources should help in thinking through the issues which must be addressed in developing national HIV policies.

Resources:

Hardee, K., I. Feranil, J. Boezwinkle, and B. Clark. 2004. "The Policy Circle: A Framework for Analyzing the Components of Family Planning, Reproductive Health, Maternal Health, and HIV/AIDS Policies." POLICY Working Paper Series No. 11. Washington, D.C.: Futures Group.
The Policy Circle is a framework that can be used to analyze the policy making process, from inception through implementation. It offers explanations and illustrations of six components, and can be applied to local, national, sectoral, or operational policies. While it can also be useful for any sector, including integration, the paper applies the framework to FP, RH, safe motherhood, and HIV/AIDS.

The six components of the policy process according to the Policy Circle are listed below.

<u>Problem</u>

Identification of a problem is central to the policy process. Problems usually involve data-based evidence, such as a high maternal mortality, or low contraceptive prevalence rate. Often, multiple policies are needed to solve a given problem.

People
Stakeholders can be individuals or organizations that affect or are affected by the policy in development. Public sector individuals can include politicians, government bureaucrats and technocrats from health, education, finance, local government. Institutions can be international organizations, donors, civil society groups, NGOs, or advocacy groups.

Process
Once a problem is identified, the policy development process begins. As outlined in the Policy Circle, the process involves issue framing, agenda setting, and policy formulation. The framework also explains three activities associated with the process. They are advocacy, policy dialogue, and data analysis. The process part of policy development can be very lengthy, as it is common for stakeholders to disagree. Policy formulation alone can take years as policymakers debate the details.

Price Tag
The Policy Circle defines cost as financial, physical, and human resources. Even the best planned policies will founder of they that lack resources, and plans must be made in advance to secure funds if a policy is expected to succeed.

Paper
This section of the policy circle addresses the actual policy document. This may take the form of a law, national or local policy or plan, an operational policy, or a resource allocation plan. The "paper" is analyzed in the Policy Circle for appropriate gender, human rights, and youth content.

Programs/Performance

Programs implement policies, and any implementation plan requires monitoring and evaluation. The Policy Circle framework and the additional tools located in the CD version can help asses an implementation plan and highlight any potential obstacles that may be encountered.

The Policy Compendium
The HIV/AIDS Policy Compendium is a searchable database containing policy statements from National HIV/AIDS policies and International resolutions. Its purpose is to provide those involved in drafting HIV/AIDS policies with examples of how specific issues were dealt with in other policies. The database offers searches by keyword, country, and/or region. Many of the policies either specifically call for or allude to the integration of HIV/AIDS services into FP clinics or vice versa.

http://64.242.197.201/

Strachan, M., A. Kwateng-Addo, K. Hardee, et al. 2004. "An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries." POLICY Working Paper Series No. 9. Washington, D.C.: Futures Group.
"An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries" focuses on the integration of FP into STI and HIV/AIDS programs. The paper analyzes how the international guidelines, national HIV/AIDS policies, and PMTCT/VCT policies of 16 countries with a high prevalence of HIV have addressed FP. This working paper also examines the gaps in including FP in PMTCT and VCT services in the selected countries.

Uganda Ministry of Health. 2005. "Uganda National Policy Guidelines for HIV Counselling and Testing." (Draft) June.
This document lays out the guidelines for how HIV counseling and testing should be carried out in Uganda. FP is considered a component of a comprehensive HIV care package.

IV. Family Planning and HIV Integration in Operational Policies

It is crucial to integrate operational policies for FP/MCH services and STI/HIV/AIDS and address any existing operational barriers in provision of RH services that may be compounded by integration. Hardee et al., 2005

What are operational policies?

While national policies provide the vision for improvement in health, operational policies give the roadmap for translating those national visions into programs and services (see Figure 1, adapted from Cross, Jewell, and Hardee, 2001).

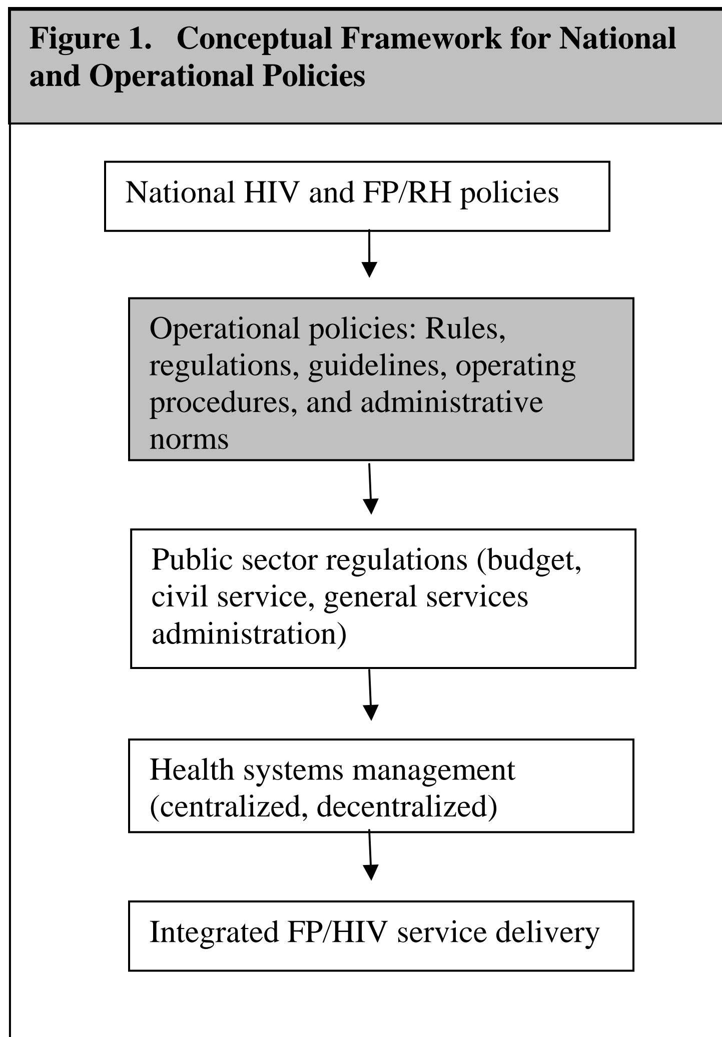

Figure 1. Conceptual Framework for National and Operational Policies

Operational policies are "the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services" (Cross, Jewell, and Hardee, 2001:v). Operational policies can be found in public sector regulations, health systems management and at the service delivery level. They are the means for implementing national policy because they translate general guidance into program-related decision making.

At the operational level, service delivery guidelines, protocols and policies need to explicitly address how FP can be integrated into new or existing services, and ensure adequate support.

Why are operational policies important for integration?

To integrate services and programs and to scale them up beyond pilot projects requires

attention to the policies and procedures that govern the programs. While counseling can most easily be integrated, merging other services requires assuring that the delivery requirements of the services are compatible (Foreit, Hardee, and Agarwal, 2002). Integration of programs can require decisions related to many aspects of operational polices, including staffing and job descriptions, facilities renovation, hours and days of operation, and training, among others.

Both human and financial resources are crucial to making integration work. Guidelines should carefully address counseling, emphasizing dual protection of condoms, quality counseling services, refresher training, and the institution of standard counseling protocols. Further, adequate dissemination of protocols is critical to ensure that providers know what is expected of them. Legislative guidelines need to be reviewed and adapted as necessary to ensure that providers can legally provide necessary services. Technical guidelines for training staff should be adapted to train staff in both RH/FP and STI/HIV issues. Supervision and follow-up among service providers should be conducted to ensure that the guidelines are being implemented.

Failure to address these issues can lead to significant operational barriers. These operational barriers manifest themselves as issues with service delivery, including inefficiency and wastage. Operational barriers can stem from operational policies that are presumed to exist but do not, as well as from misguided policy design or a policy vacuum. The following four broad steps can be applied to address these barriers:

1. Understanding the public sector
2. Setting up a collaborative system for identifying barriers
3. Conducting analyses to identify policy roots of the barrier
4. Following through with the recommendation of the analysis to remove the policy barriers. (Cross, Jewell, and Hardee, 2001:12)

By applying these steps to issues that arise in delivering integrated FP and HIV services, operational barriers can be addressed. A study of the policy barriers to effective integration in Jamaica found that by adapting human resource policies, redesigning record keeping systems, and implementing new staff training, Jamaica's public health system would have greater success with integrated FP/HIV services (Packer et al., 2004).

Resources:

Cross, H., K. Hardee, and N. Jewell. 2001. "Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs." Policy Occasional Paper, No. 7. Washington, D.C.: Futures Group.
The paper discusses the nature of operational policies, stresses the important role they play in the continuum from national decrees to local services, and provides a framework for operational policy reform. The operational policy reform process calls for the following:

- understanding the public sector, which gives rise to the policies that shape the service environment
- setting up a collaborative system with managers and providers for identifying operational barriers to high-quality RH care
- conducting analyses to determine the operational policy roots of those
- barriers
  adopting recommendations and strategies to remove the operational policy barriers

The process of analyzing operational policies and devising reform strategies is most effective as a participatory endeavor that draws on the insights and perspectives of those who manage and provide RH care services and those who set policies.
The paper also provides evidenced based examples of how operational policy analyses have illuminated the debilitating effects of outdated or nonexistent policies on reproductive services in a number of countries, including Guatemala, Haiti, India, Jordan, the Philippines, Romania, and Ukraine. The analyses led to reform initiatives that helped governments at all levels. Analyzing operational policies and supporting policy reform is a highly effective tool for improving the delivery of much-needed RH care services in developing countries.

Family Health International. 2005. Contraception for Women and Couples with HIV. < http://www.fhi.org/training/en/modules/ARV/default.htm> cited October 2005.

This website, created by Family Health International, aims to educate providers/counselors who provide contraception to HIV positive individuals. The website contains:

1) Learning module/presentation with an overview of the key issues
2) Pre/post test to assess knowledge gaps and achievements
3) Additional materials such as fact sheets, handouts, references and resources.

http://www.fhi.org/training/en/modules/ARV/default.htm

Pathfinder International. ND. "Clinic Assessment Guide." Watertown, MA: Pathfinder International.
This guide is intended as an instrument for conducting integrated facility needs assessments, with the expectations that its application will enable the design of more effective programs (page 1).

Assimwe, D, R Kbomo, J Matsiko and K Hardee. 2005. Study of the Integration of FP and VCT/PMTCT/ART Programs in Uganda. Kampala: Makerere Institute of Social Research and Washington, D.C.: Futures Group, POLICY Project. Forthcoming.

Packer, L., L. Moriss, S. Taylor, J. McGregor, C. Leckie, K. Hardee, K. McClure, M. Rowan, C. Shepherd, and B. Clarke. 2004. Determining the Feasibility and Potential Scope of Integration of Reproductive Health (FP/MCH/STI/HIV) Services, Using Portland and St. Ann's Bay as Pilot Sites. Kingston, Jamaica: KPMG and Washington D.C.: Futures Group, POLICY Project.
This report summarizes activities in Jamaica to assess the feasibility of integrating FP/MCH and STI/HIV services, using the parish of Portland and St. Ann's Bay Health District as pilot sites. The report includes numerous forms of integration interventions, the costs of these interventions and potential barriers to implementation.

V. Family Planning in Voluntary Counseling and Testing

Why should VCT policies include FP?

✓*VCT provides an opportunity to present information on safer sexual behavior.* Large numbers of people face the risk of both unintended pregnancy and HIV/STIs through unprotected sex. In a single random unprotected sex act, the probability of pregnancy is 3.5 percent (Bongaarts and Potter, 1983) and the probability of HIV infection is 0.001 percent (male to female) and .0006 percent female to male (Mastro et al, 1996 and Mastro et al 1998). Counseling can affect behavior change through improved decision making. Armed with information, individuals and couples have a greater ability to reduce their risk of infection, and are better prepared to achieve their fertility goals through choosing appropriate contraceptive methods

What is VCT?
VCT is a process by which an individual undergoes counseling to help him make an informed choice about being tested for HIV, decides whether or not to be tested, and if he or she does get tested, receives their results. The integration of FP to this process provides an opportunity to reach many people with unmet need for contraception who might not otherwise seek out FP services. It may reach a wider variety of clients than traditional FP clinics, which primarily serve women.

✓*VCT can attract vulnerable groups.* RH information and education through FP programs is traditionally targeted primarily to married women. Integrated services provide an opportunity to reach a broader audience, including men and youth.

Men. Gender imbalances make it imperative that men have the knowledge and skills to lower risk of infection, change perceptions about condom use, and adopt healthy RH behaviors.

Youth. HIV prevalence in Africa is increasing most rapidly among 15- to 24-year-olds, the most sexually active and fertile age group. However, youth face significant cultural barriers in seeking RH information and services. Counseling on delaying sexual debut and adoption of safer sex behaviors, particularly dual protection methods in the adolescent years, can significantly reduce the spread of HIV/AIDS and unintended pregnancy among adolescents and young adults

✓*Dual protection counseling should be a component of risk reduction planning.* High unmet need for FP, low contraceptive prevalence, and rising prevalence of STIs highlight the urgent need for promotion of dual protection. Dual protection can be achieved either through the use of a condom or through the use of a condom in combination with another contraceptive method, a better option for those who desire to space or limit childbearing. VCT provides an ideal opportunity to discuss FP, in addition to other risk reduction strategies.

Kenya has taken the first steps towards this kind of integration. Nearly 300 VCT centers have been registered and Kenya has developed country-specific VCT guidelines that include FP (FHI 2004a, page12).

Are there any guidelines for integrating FP into VCT?

Strachen et al. (2003) summarized available guidelines on integration of FP in the HIV/AIDS policies, including VCT. Among others, in 2002, the South African Development Community developed model guidelines for VCT that are intended to serve as a resource for countries establishing country guidelines and programs. FP is mentioned as one of the six key components of a comprehensive VCT program.

- **Structured systems for referral to relevant prevention, treatment, and support services** for prevention and treatment of syphilis and other STIs; prevention, screening and treatment of Tuberculosis (TB); FP services; MCH services; legal assistance; post-test support groups; treatment of HIV-related illnesses; and hospital and home-based care.

- **Service plans should include access to affiliated essential services through development and support of linkages to other sectors and referral networks** for both HIV-positive and HIV-negative clients. VCT sites should be established concurrently with integration into affiliated services to provide a continuum of care and support for as many clients as feasible. There are multiple levels of linkages—regional, national, district and site—necessary to create an enabling environment for VCT services and to ensure coordinated implementation. In addition to developing these various levels of referral networks—among medical, psychosocial, community- and home-based care and support services—it is imperative that VCT service plans include direct assistance to clients seeking and complying with these services. Affiliated services include psychological and social support; palliative care; treatment for pneumonia, candidiasis, pulmonary TB, and STIs, nutritional counseling, FP, cotrimoxazole prophylaxis (for the prevention of several secondary bacterial and parasitic infections in people living with HIV/AIDS), and facilitation of other community activities that mitigate the impact of HIV/AIDS. This will require the establishment of procedures for follow up and case management of clients.

The guidelines designate several guiding principles to effective VCT, including the following:

> **Couple counseling** is recommended, since it has been shown to effectively help couples make informed decisions about sexual relationships, marriage, and FP/pregnancy and to promote behavior change.

These guidelines also apply to routine counseling and testing programs, where people are routinely offered HIV testing as part of contact with the health system. Because this routine offer of testing could reach TB and STI patients, those going for operations, and other care, this could increase the reach even more of integrated FP services.

Resources

Family Health International. 2003. Assessment of Voluntary Counseling and Testing Centers in Kenya. Research Triangle Park, NC: Family Health International.
This study gathered information about VCT services in Kenya in an effort to identify and to formulate programmatic options for effective integration of FP into VCT services. The study addressed the following questions (page 1):

- Is there potential demand for FP services among VCT clients?
- Is the provision of FP services during VCT sessions acceptable to the clients, providers, and VCT center in-charges?
- What elements of contraceptive counseling and distribution are VCT services in their current form ready to offer?
- Is it feasible to provide FP services within the VCT service environment?

The study found low levels of referrals to FP services and inadequate counseling on contraceptive use.

Family Health International. 2004. "Network: Integrating Services." Vol. 23; No. 3. Research Triangle Park, NC.: Family Health International.
This collection of articles addresses a number of topics, including how to decide whether integration is an appropriate strategy for the setting, integration case studies, and the potential benefits and challenges of integration.

Family Health International. 2004. "Research to Practice: Underused Research Findings." Research Triangle Park, NC: Family Health International.
This document contains findings from various studies (published and unpublished) on FP and HIV/AIDS services integration and on numerous modern contraceptive methods.

Strachan, M., A. Kwateng-Addo, K. Hardee, et al. 2004. "An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries." POLICY Working Paper Series No. 9. Washington, D.C.: Futures Group.
"An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries" focuses on the integration of FP into STI and HIV/AIDS programs. The paper analyzes how the international guidelines, national HIV/AIDS policies, and PMTCT/VCT policies of 16 countries with a high prevalence of HIV have addressed FP. This working paper also examines the gaps in including FP in PMTCT and VCT services in the selected countries.

Uganda Ministry of Health. 2005. "Uganda National Policy Guidelines for HIV Counselling and Testing." (Draft) June.
This document lays out the guidelines for how HIV counseling and testing should be carried out in Uganda. FP is considered a component of a comprehensive HIV care package.

UNAIDS. 2001. "Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues." New York: UNAIDS.

UNAIDS Best Practice Collection's *Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues* (2001) aims "to provide guidance on the counseling and HIV testing for managers of antenatal clinics and other pregnancy-related services, whether they are public, private or non-profit. [The document] may also be used as a basis for discussion in developing a national policy in this increasingly important area." The publication mentions several times that FP is essential to both pre- and post-counseling in antenatal care (ANC) sessions for HIV-positive women. It also discusses the involvement of men relative to fertility decisions.

UNAIDS. 1999. "Knowledge is Power: Voluntary HIV Counseling and Testing in Uganda." New York: UNAIDS.

This case study of interventions used in Uganda to address and mitigate the HIV/AIDS epidemic includes a section on integration of FP services. In the clinics studied, FP services are offered along with HIV/AIDS services.

Wilcher, R. and E. Martin. 2004. "Integrating Family Planning and Voluntary Counseling and Testing Services in Ghana: A Rapid Programmatic Assessment." Research Triangle Park, NC: USAID, Family Health International, and Ghana Health Service.

This report attempts to show the current demand for and provision of integrated FP and HIV/AIDS services, specifically in Ghana. Through a review of existing literature and open-ended interviews with key FP and HIV/AIDS informants, the report concludes with the following two points:

- Majority of interviewees support integration
- Challenges to integration center around logistics, human resource capacity, quality of care and stigma coupled with gender dynamics

The report includes recommendations for strengthening linkages between FP and VCT.

World Health Organization. 2002. "Increasing Access to HIV Testing and Counseling: Report of a WHO Consultation November 19–21, 2002." Geneva: WHO.

This report covers the findings of a World Health Organization (WHO) Consultation on Increasing Access to HIV Testing and Counseling, held in Geneva, Switzerland in November 2002. It summarizes the rationale for increasing access to HIV testing and counseling and details guiding principles for these activities. Protocols for testing and counseling content include FP information in the education and counseling segments.

VI. Family Planning in Prevention of Mother-to-Child-Transmission

Why should PMTCT policies include FP?

✓*FP is a key component of PMTCT.* Family planning is a vital component of ANC, where PMTCT services are typically situated. The World Health Organization (WHO) recommends that by week 32 of gestation, clients be encouraged to discuss birth spacing and contraceptive options with the partners, and be able to get their contraceptive method of choice (UNAIDS, 2002). UNAIDS estimates that up to 35 percent of children are infected vertically (i.e., from mother to child during pregnancy, childbirth, or breastfeeding) (UNAIDS, 1998). Postnatally, HIV-positive women can use contraception to avoid future unintended pregnancies and stem vertical transmission.

What is PMTCT?
The overarching goal of PMTCT programs is to reduce the possibility of vertical transmission (transmission of HIV from the mother to the infant). Therefore, PMTCT programs take place most often in ANC settings. In a comprehensive PMTCT program, the main strategies for reducing the numbers of infants infected with HIV are as follows:

- Primary prevention (protecting women in the reproductive age group and their partners from becoming infected with HIV);
- Provision of family planning services to enable women to avoid unintended births—the cornerstone of PMTCT; and
- Provision of VCT, ART, and minimizing invasive obstetric procedures during labor and delivery (such as cesarean sections), and counseling on infant feeding options. (UNAIDS, 2002).

✓*Prevention of unintended pregnancies.* All women have the right to voluntarily and responsibly decide the number and spacing of their children and the means to do so. However, providing FP counseling to HIV-positive women is often not a priority. It is vital that HIV-positive women understand the risks of vertical transmission and have the knowledge and skills to make decisions regarding future pregnancies. For HIV-positive women who have the option to use formula rather than to breastfeed, a discussion of contraceptive options is critical, since they will not be protected from pregnancy by lactational amenorrhea. To prevent pregnancy, women (or their partners) should begin using a contraceptive method within 4 to 6 weeks postpartum.

✓ *Providing FP as part of PMTCT contributes to meeting PMTCT goals.* The UN General Assembly declared as a goal to “reduce the proportion of infants infected with HIV by 20 percent by 2005, and by 50 percent by 2010, by ensuring that 80 percent of pregnant women accessing antenatal care have information, counseling and other HIV-prevention services available to them …” These goals will be difficult to reach without the integration of FP to PMTCT.

✓ *FP as part of PMTCT is a cost effective method of limiting HIV-positive births, orphans as a result of HIV/AIDS, and maternal mortality.* A computer simulation of the costs and benefits of adding FP to PMTCT services in the 14 President's Emergency Plan for AIDS Relief countries looked at two PMTCT regimes, nevirapine-only (NVP) and zidovudine plus nevirapine (AZT+NVP).

The analysis found that the NVP-only regime would decrease HIV-positive births by 10 percent and the addition of FP to these services would result in an overall reduction of HIV-positive births by 18 percent. With the AZT + NVP regime, infant HIV infections could be reduced by 19 percent. The addition of FP brings the infection rate down by another four percent, for a total reduction of 23 percent.

In many cases, the addition of FP to PMTCT is a cost-effective intervention. The NVP-only regime cost per child infection averted is US$2,000, while the FP cost per child infection averted is US$830. While the AZT + NVP regime is more costly, FP still costs less than PMTCT if brand name antiretrovirals are used. If generic drugs are available, PMTCT costs less than FP to avert child infections (Policy Project, 2005).

The link between FP and PMTCT has been recognized. Strachan et al. (2004) reported on the UNAIDS Best Practice Collection *Mother to Child Transmission of HIV: A Technical Update* (1998) which suggested that one component of a successful response to mother-to-child transmission (MTCT) is a link to FP programs:

> All women and men, irrespective of their HIV status, have the right to determine the course of their reproductive life and health, and to have access to information and services that allow them to protect their own and their family's health. Links between HIV testing programmes and FP services must be strengthened in order for HIV-infected women and their partners to make informed choices regarding their future reproductive life. One specific point is that breastfeeding has a birth-spacing effect that will disappear (and should be replaced) if the woman chooses not to breastfeed her infant. Failing to address this issue through counseling and education can result in more HIV-positive infants being borne than would otherwise be the case.

However, the assumption is often made that FP is available "somewhere in the building" and that PMTCT programs do not need to strengthen those programs. Operational policy analysis can help determine operational barriers to fuller integration of FP and PMTCT and to identify and address policy roots of the operational barriers.

Resources:

Baek, C. and N. Rutenberg. 2005. "Addressing the Family Planning Needs of HIV-Positive PMTCT Clients: Baseline Findings from an Operations Research Study." ***Horizons Research Update*****. Washington, D.C.: Population Council.**
This research update presents key findings about FP at PMTCT sites, including the interaction between providers and clients as well as HIV-positive women's fertility desires and demand for contraceptives, from the baseline cross-sectional survey and qualitative interviews with postpartum women (page 1).

Best, Kim. 2004. "Family Planning and the Prevention of Mother-to-Child Transmission of HIV: A Review of the Literature." Research Triangle Park, NC.: Family Health International.
This document reviews current literature on FP and PMTCT. Key messages that emerge include the following:

- FP services can greatly contribute to preventing HIV-positive births.
- Increasing contraceptive use to prevent unintended pregnancy among HIV-infected women appears to be at least as cost effective as providing nevirapine to HIV-infected mothers.
- Contraceptive considerations for HIV-infected women are unique.
- HIV-infected women are no different from uninfected women in their need to decide the number and timing of their children. Counselors working with this population should support their decisions.
- FP, in itself, provides important benefits to women and their families.

The literature review is organized around the following themes:

- Preventing unintended pregnancy in HIV-infected non-pregnant women
- Preventing future pregnancy among HIV-infected women who are already pregnant
- Preventing HIV infection among uninfected women who are not pregnant
- Preventing HIV infection in uninfected women or women of unknown status who are pregnant

Examples of programs and policies are provided on each theme.

Duerr, A., S. Hurst, A.P. Kourtis, N. Rutenberg, and D.J. Jamieson. 2005. "Integrating Family planning and prevention of Mother-to-Child HIV Transmission in Resource-Limited Settings." *The Lancet* 366:261–263.
This paper provides a short review of the rationale for the integration of FP and HIV services and the advantages of such a union. The paper highlights the fact that modern contraceptives are generally available in many of the areas of high HIV infection and that this intervention would be as effective as other PMTCT interventions (page 262).

Family Health International. 2004. "Network: Integrating Services." Research Triangle Park, NC.: Family Health International.
This collection of articles addresses a number of topics, including how to decide whether integration is an appropriate strategy for the setting, integration case studies, and the potential benefits and challenges of integration.

Family Health International. 2004. "Research to Practice: Underused Research Findings." Research Triangle Park, NC: Family Health International.
This document contains findings from various studies (published and unpublished) on FP and HIV/AIDS services integration and on numerous modern contraceptive methods. It highlights the cost effectiveness of integrating FP into PMTCT services, and the benefits and challenges of integrating FP into VCT.

Integrated Health Resources Consultants Company. 2005. "Strengthening Family Planning within PMTCT Programme in Uganda: Needs Assessment Report."
This report is a needs assessment of the FP gaps at seven PMTCT sites in Uganda. The identified gaps are intended to form the basis for interventions to strengthen FP within the Uganda PMTCT program. The assessment found several shortcomings in the FP services offered at PMTCT programs, including FP services located in different buildings than MCH services, low levels of FP knowledge among providers, lack of support to HIV-positive women and lack of FP supplies and drugs at many health centers (pages 6 and 7).

Policy Project. 2005. "Family Planning Services as a Component of Prevention of Mother-to-Child Transmission (PMTCT) Programs." Internal presentation. Washington, D.C.: POLICY Project.
This booklet considers the role that FP can play in helping countries limit MTCT. The highlighted intervention is FP to prevent MTCT. Projections for 14 countries on the effect of integrating FP into PMTCT services are included.

Preble, E.A., D. Huber and E. G. Piwoz. 2003. "Family Planning and the Prevention of Mother-to-Child Transmission of HIV: Technical and Programmatic Issues." Arlington, Virginia: Advance Africa.
This paper addresses the lack of FP counseling and services for HIV-infected women in Africa. It outlines FP issues specific to HIV-infected women, operational and programmatic considerations to enhance access to FP by HIV-infected women, as well as recommendations on how to improve access to FP for HIV-infected African women.

Reynolds, H., B. Janowitz, R. Homan, and L. Johnson. ND. "Cost Effectiveness of Two Interventions to Avert HIV-Positive Births." Research Triangle Park: FHI.
This report compares the cost effectiveness of increasing contraceptive use among non-pregnant women vs. increasing coverage of perinatal care services to provide and promote nevirapine for PMTCT. By simulating costs, contraceptive use, and availability of nevirapine, the study found that at any level of expenditure increasing contraceptive use averted more HIV-positive births (page 2).

Rutenberg, N. et al. 2003. "Family Planning and PMTCT Services: Examining Interrelationships, Strengthening Linkages." ***Horizons Research Summary*****. Washington, D.C.: Population Council.**
This summary presents the findings of several studies that examined the extent to which VCT and PMTCT programs in 11 countries include FP and vice versa. These studies found that on the whole most PMTCT sites offer FP services, with the exception of some sites run by faith based organizations. However, the existence of FP services at PMTCT sites does not necessarily mean the two are integrated; the study found very little integration of HIV issues into FP services and the different FP needs of HIV-positive women at PMTCT sites. In addition, it was found that including PMTCT into ANC/MCH services can improve the quality of existing FP services.

Rutenberg, N., C. Baek, S. Kalibala, and J. Rosen. 2003. "Evaluation of United Nations-Supported Pilot Projects for the Prevention of Mother-to-Child Transmission of HIV: Overview of Findings." New York, NY: UNICEF.
"This overview report presents key findings from an evaluation of UN-supported pilot PMTCT projects in eleven countries, including: Botswana, Burundi, Cote d'Ivoire, Honduras, India, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe. Key findings discuss: feasibility and coverage; factors contributing to programme coverage; programme challenges; scaling-up; the special case of low prevalence countries; and recommendations."

Rutenberg, N. and C. Baek. 2004. Review of Field Experiences: Integration of Family Planning and PMTCT Services." Washington, D.C.: Population Council.
This report reviews field experiences with the integration of FP and PMTCT services (page 4).

Rutenberg, N. and C. Baek. 2005. "Field Experiences Integrating Family Planning into Programs to Prevent Mother-to-Child Transmission of HIV." ***Studies in Family Planning*****. 36(3):235–245.**
"This article reviews field experiences with provision of FP services in prevention of mother-to-child transmission programs in 10 countries in Africa, Asia, and Latin America" (page 235). The public health approach to PMTCT for HIV-positive women is contrasted with the reproductive rights approach.

Strachan, M., A. Kwateng-Addo, K. Hardee, et al. 2004. "An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries." POLICY Working Paper Series No. 9. Washington, D.C.: Futures Group.
"An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries" focuses on the integration of FP into STI and HIV/AIDS programs. The paper analyzes how the international guidelines, national HIV/AIDS policies, and PMTCT/VCT policies of 16 countries with a high prevalence of HIV have addressed FP. This working paper also examines the gaps in including FP in PMTCT and VCT services in the selected countries.

UNAIDS/UNICEF/WHO. 1998. "HIV and Infant Feeding: Guidelines for Decision-makers." Geneva: WHO.
The UNAIDS/UNICEF/WHO *HIV and Infant Feeding: Guidelines for Decision-makers* (1998) These guidelines focus on increasing access to both VCT and FP information and services for all women, ensuring that nonbreastfeeding mothers have access to FP, and strengthening existing services to meet the needs of HIV-positive women.

UNAIDS. 1998. "Mother to Child Transmission of HIV: A Technical Update." New York: UNAIDS.
The UNAIDS Best Practice Collection's *Mother to Child Transmission of HIV: A Technical Update* (1998) suggests that one component of a successful response to MTCT is a link to FP programs:

"All women and men, irrespective of their HIV status, have the right to determine the course of their reproductive life and health, and to have access to information and services that allow them to protect their own and their family's health. Links between HIV testing programmes and family planning services must be strengthened in order for HIV-infected women and their partners to make informed choices regarding their future reproductive life. One specific point is that breastfeeding has a birth-spacing effect that will disappear (and should be replaced) if the woman chooses not to breastfeed her infant. Failing to address this issue through counseling and education can result in more HIV-positive infants being borne than would otherwise be the case."

UNAIDS and WHO. 2004. "National Guide to Monitoring and Evaluating Programmes for the Prevention of HIV in Infants and Young Children" Geneva: WHO.
This document describes the various interventions available to prevent PMTCT and provides indicators by which managers can determine the effectiveness of their PMTCT programs. Included in the list of PMTCT interventions are FP services which include testing and counseling and the need for dual protection.

World Health Organization. 2000. "New Data on the Prevention of Mother-to-Child Transmission of HIV and their Policy Implications: Conclusions and recommendations." WHO Technical Consultation on Behalf of UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV. October 11-13, 2000.
This paper contains a review of the ARV regimens to prevent MTCT and how they should be used in resource poor settings. One of the conclusions reached is that FP services are especially important for HIV-infected women who do not breastfeed.

VI. Family Planning in Antiretroviral Therapy

Why should ART policies include FP?

- ✓ *Clients on ART want access to FP*. HIV-positive women and men often desire to have no more children and they often want services at the same place they get their ARV services – from providers who know them and their situations. Adding contraceptive care to ART facilities should be undertaken to improve the health and wellbeing of clients.

- ✓ *Initiating FP as an integral component of ART as services are set up will be easier than adding FP later*, once policies, guidelines and protocols have been firmly established.

- ✓ *Consistent contact with health system offers opportunity to increase exposure to FP.* Women who are on ART will have sustained contact with health care providers. These providers, when adequately trained, can serve as an exposure point for contraceptive options and education. In addition, HIV-positive women may be less willing to go to FP clinics due to fear of stigma and discrimination. Providing these services along with ART will reduce this fear.

- ✓ *FP can reduce the number of unintended pregnancies among HIV-positive women.* The impact of averting unintended pregnancy among this group is far reaching and includes reductions in the number of new infections transmitted from mother to child and limiting future HIV/AIDS-related orphans and vulnerable children.

- ✓ *FP allows HIV-positive men and women to better plan their reproductive life and choose when and if to conceive.* Because ART is a life-long regimen, continued FP support through the ART provider is essential.

- ✓ *ART services attract a broader range of clients that can be served by FP information.* While traditional FP outlets cater to married women, ART service centers serve additional groups such as men and youth that can also benefit from the provision of FP information, services, and commodities.

- ✓ *Some antiretroviral regimens may limit the number of methods that are appropriate or accessible to women.* Providing FP guidance in the context of ART can help ensure that positive

What is antiretroviral therapy?
Antiretroviral therapy, or ART, is a treatment that uses ARV medicines to suppress viral replication and improve symptoms. Effective ART requires the simultaneous use of three or four ARV medicines as specified in the WHO "Guidelines for a Public Health Approach, Scaling up antiretroviral therapy in resource-limited settings" (June 2002). These guidelines are intended to support and facilitate proper management and scale-up of ART, providing recommended first and second line treatment for adults and for children, reasons for changing ART, monitoring patients, side effects of ART, and specific recommendations for certain patient subgroups.

women are making informed choices about their contraceptive method.

- ✓ *Method effectiveness varies.* While condoms are an effective barrier method for prevention of HIV transmission, ART clients should be provided additional information about dual protection and other contraceptive methods that are more effective at preventing pregnancy than condoms.

- ✓ *Impact of ARVs on infants is still unclear.* Little is known about the effects of ARTs on the fetus and newborn. Clinical trials in human pregnancy have been conducted for several drugs, including Zidovudine and Nevirapine. In these trials, there was no increase in the birth defects between the drug and placebo groups. However, there is evidence of toxicity for pregnant women and fetuses with certain ARVs (Public Health Service Task Force, 2003; Newell, 2001). FP can be recommended for HIV-positive women until more is understood about the short- and long-term benefits and risks of ARVs.

Resources:

Attawell, K. and J. Mundy. 2003. "Provision of Antiretroviral Therapy in Resource-Limited Settings: A Review of Experience up to August 2003." London: World Health Organization and UK Department for International Development.
This paper studies the requirements for introducing and scaling up provision of ART as part of comprehensive HIV/AIDS programs in resource-poor countries. The feasibility of ART, the different approaches to delivery of ART and the issues to be considered in scaling up ART are specifically looked at. The paper contains examples of integration of ART into existing health care systems including the integration of ART and FP services.

Family Health International. 2004. "Network: Integrating Services." Research Triangle Park, NC.: Family Health International.
This collection of articles addresses a number of topics, including how to decide whether integration is an appropriate strategy for the setting, integration case studies, and the potential benefits and challenges of integration.

Global HIV Prevention Working Group. 2004. "HIV Prevention in the Era of Expanded Treatment Access." Seattle, WA: Bill and Melinda Gates Foundation
"This report by the Global HIV Prevention Working Group makes detailed recommendations on how to effectively integrate HIV prevention into expanding HIV treatment programs. The report also provides recommendations on new approaches to HIV prevention that will be required as treatment access expands, including programs that take into account the different needs of people who are HIV-positive and HIV-negative, " including FP.

Government of India. 2004 *National Guidelines for Implementation of Antiretroviral Therapy*. Draft. New Delhi: National AIDS Control Organization.

This draft of India's national guidelines for antiretroviral therapy includes guidance on messages for people living with HIV/AIDS. This guidance includes offering FP and advising on the different options (page 69).

Shelton, J.D. and E.A. Peterson. 2004. "The Imperative for Family Planning in ART in Africa" ***The Lancet*** **364:1916–1917.**
This Lancet article lays out the arguments for integrating FP into antiretroviral therapy in Africa. Need for contraception among all groups is high in Africa and HIV-infected women may have even greater need for contraception, due to the extraordinary life stresses associated with the disease. Antiretrovirals have the potential to harm fetuses *in utero*. Contraception can also prevent MTCT of HIV by preventing unintended pregnancy.

World Health Organization. 2000. "New Data on the Prevention of Mother-to-Child Transmission of HIV and their Policy Implications: Conclusions and recommendations." WHO Technical Consultation on Behalf of UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV. October 11–13, 2000.
This paper contains a review of the ARV regimens to prevent MTCT and how they should be used in resource poor settings. One of the conclusions reached is that FP services are especially important for HIV-infected women who do not breastfeed.

World Health Organization. 2004. "Emergency Scale-up of Antiretroviral Therapy in Resource-Limited Settings: Technical and Operational Recommendations to Achieve 3 by 5." Report of the WHO/UNAIDS International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-up of Antiretroviral Therapy in Resource Limited Settings. Nov. 18–21, 2003.
This paper contains recommendations and priority actions that are required to deliver antiretroviral therapy in a short time frame. Recommends including HIV prevention services such as FP in ARV therapy programs.

World Health Organization. 2003. "Scaling up Antiretroviral Therapy in Resource Limited Settings: Treatment Guidelines for a Public Health Approach." Geneva: WHO.
These antiretroviral guidelines provide comprehensive instruction on the use of antiretroviral therapy in developing countries among differing sub-populations. Included is a short section on pregnant women and women of childbearing potential. Specific information is given on the use of ARV in pregnancy and the effects of ARV on hormonal contraception and vice versa. It recommends that women who are on ARV therapy and do not what to become pregnant have effective and appropriate contraceptive methods made available.

VII. Additional Resources

Other resources that may be helpful to readers include both general and country-specific resources.

General

Askew, I. and M. Berer. 2003. "The Contribution of Sexual and Reproductive Health Services to the Fight Against HIV/AIDS: A Review." ***Reproductive Health Matters*** **11(22):51-73.**
This paper reviews and assesses the contributions made to date by sexual and RH services to HIV/AIDS prevention and treatment. The paper concludes that more integrated programs of sexual and RH care and STI/HIV/AIDS control should be developed to jointly offer certain services, expand outreach to new population groups, and create well-functioning referral links to optimize the outreach and impact of essentially vertical programs (page 51).

Berer, Marge. 2003. "HIV/AIDS, Sexual and Reproductive Health: Intimately Related." ***Reproductive Health Matters*** **11(22):6–11.**
This article explicates the reasons that HIV/AIDS services and RH services are often not integrated as well as the often philosophical challenges to integrating the two.

EngenderHealth. 2004. "Preventing HIV/AIDS Through Family Planning." New York: EngenderHealth.
This article explains the importance and relevance of FP in preventing the spread of HIV/AIDS.

Family Health International. 2004. "Network: Integrating Services." Research Triangle Park, NC.: Family Health International.
This collection of articles addresses a number of topics, including how to decide whether integration is an appropriate strategy for the setting, integration case studies, and the potential benefits and challenges of integration.

Family Health International. 2005. "Contraception and HIV Factsheet" Research Triangle Park, NC: Family Health International
This briefing contains information on the interaction of contraceptives and HIV/AIDS , namely the potential for some contraceptive methods to prevent HIV/AIDS. The conclusion is that only condoms have been shown to protect against the spread of HIV/AIDS.

Family Planning and HIV Web Site
The Family Planning and HIV/AIDS Integration site is a Web site that includes information on and links to over 300 journal articles, PowerPoint presentations, and other materials about FP and HIV/AIDS integration.

It can be found on the internet at http://www.fpandhiv.org

Foreit,K., K. Hardee, and K. Agarwal. 2002. "When Does it Make Sense to Consider Integrating STI and HIV Services with Family Planning Services?" ***International Family Planning Perspectives*** **28(2):105–107.**
This article considers the populations served by facilities as an important factor to consider before integration of FP and HIV/AIDS services.

Hamilton, Margaret. 2005. "Ensuring Contraceptive Security for HIV-Positive Women." ***POLICY Issues in Planning and Finance*** **No. 5. Washington, D.C.: POLICY Project.**
As developing countries strive to achieve contraceptive security (CS) amid growing demand for contraceptives and the removal of long-term donor support, the direction of resources towards vulnerable groups, including HIV-positive women, has become increasingly important. Many CS programs, however, do not successfully accommodate the special needs of HIV-positive women. This brief describes the importance of ensuring CS for HIV-positive women. It also reviews common barriers faced by HIV-positive women as they attempt to access FP services and illustrates interventions that can increase the likelihood of overcoming these barriers.

Info Project. 2004. "WHO Updates Medical Eligibility Criteria for Contraceptives." ***Info Reports.*** **Baltimore: Johns Hopkins Bloomberg School of Public Health.**
This publication details the WHO updates on medical eligibility criteria for contraceptives. Included is information on the eligibility of HIV-positive women to use various contraceptive methods including IUD and hormonal methods.

Kane, M.M, B.A. and T.C. Colton. 2005. "Integrating SRH and HIV/AIDS Services: Pathfinder International's Experience Synergizing Health Initiatives." Watertown, MA: Pathfinder International.
This paper documents the experience of Pathfinder International in promoting and facilitating the integration of FP/SRH and HIV/AIDS services. The successes, lessons learned and challenges faced by Pathfinder are detailed.

Maqweb.org
Maqweb is the Web site of the Maximizing Access and Quality (MAQ) Initiative. The MAQ Initiative's purpose is to bring together USAID/Washington, USAID Missions, the cooperating agency community and other partners to identify and implement practical, cost-effective, and evidence-based interventions aimed at improving both the access to and quality of FP and RH services. [text from Web site] The Web site contains a variety of tools and publications to aid in the exchange of information, including many which address FP and HIV service integration.

It can be found at http://www.maqweb.org/

Mitchell, H.S. and E. Stephens. 2004. "Contraception Choice for HIV-Positive Women." London, England. Sexually Transmitted Infections Journal 80:167–173.

This article provides a global overview of contraception choice for women living with HIV infection, including effects on sexual transmission risk. It addresses method options, factors affecting consistent use, and drug interactions.

Pathfinder International. ND. "Clinic Assessment Guide." Watertown, MA: Pathfinder International.
This guide is intended as an instrument for conducting facility needs assessments, with the expectations that its application will enable the design of more effective programs (page1).

Preble, E.A. and E.G. Piwoz. 2001. "Prevention of Mother-to-Child Transmission of HIV in Africa: Practical Guidance for Programs." Washington, D.C.: Academy for Educational Development.
The purpose of this paper is "to summarize knowledge about MTCT and to provide guidance for program managers and policy makers on selecting and implementing MTCT prevention interventions." FP counseling and services that are linked to VCT are presented as a core MTCT intervention.

Stop AIDS Now, World Population Foundation, and Share-Net. 2004. "AIDS, Sex and Reproduction: Integrating HIV/AIDS and Sexual and Reproductive Health into Policies, Programmes and Services."
This issue of the AIDS, Sex & Reproduction newsletter addresses the necessity of integrating HIV/AIDS and sexual and RH programs, policies and services. The role of gender and sexuality in the HIV/AIDS epidemic, the international context and the advantages of a rights based approach are provided as a rationale for integrating HIV/AIDS and RH services. The newsletter also contains information on the current status of the integration of HIV/AIDS and RH and sexual services, along with recommendations and examples.

USAID. 2003. "Family Planning/ HIV Integration: Technical Guidance for USAID-Supported Field Programs." Washington D.C.: United States Agency for International Development.
"Family Planning/ HIV Integration: Technical Guidance for USAID-Supported Field Programs" provides suggestions and findings for effective integration approaches for both FP and HIV/AIDS program managers and is intended to help USAID field officers and managers of USAID-supported programs decide when and how to integrate FP and HIV services. It includes technical insights regarding FP/HIV integration and is a source of information regarding appropriate use of USAID funds.

It discusses key technical approaches conducive to FP/HIV integration, including:

- ABC (abstain, be faithful, and/or use a condom correctly and consistently)
- Integrated interventions and youth
- FP and PMTCT
- Voluntary counseling and testing and FP
- STIs
- Policies built on cultural values

- Community bases approaches
- Commodities and logistics systems
- Promising areas for the future

<u>Country:</u>

Aloo-Obunga, C. 2003. "Country Analysis of Family Planning and HIV/AIDS: Kenya." Washington, D.C.: POLICY Project.
This study documents the extent to which Kenya has managed both its FP/RH and HIV/AIDS programs in the context of high HIV prevalence. Key informants from relevant organizations were interviewed (page iv). One of the main findings was shift in focus from FP/RH to HIV/AIDS programs, in both monetary and policy terms.

Assimwe, D., R. Kbomo, J. Matsiko, and K. Hardee. 2005. Study of the Integration of FP and VCT/PMTCT/ART Programs in Uganda. Kampala: Makerere Institute of Social Research and Washington, D.C.: Futures Group, POLICY Project.
This study for Integration of FP and VCT, PMTCT, and ART programs in Uganda was carried out between October 2004 and February 2005 in two urban and two rural sites to assess the national policy environment regarding the possibility of providing FP services in the VCT, PMTCT, and ART settings and the existing barriers to the integration of FP in these services. A conceptual framework linking demand for and use of integrated HIV/AIDS and FP services with the policy and program systems that need to be in place was developed for the study.

Banda, H. N., S. Bradley, and K. Hardee. "Provision and Use of Family Planning in the Context of HIV/AIDS in Zambia: Perspectives of Providers, Family Planning and Antenatal Care Clients, and HIV-positive Women." Washington, D.C.: POLICY Project.
This study explores how Zambian FP services are being implemented in light of the HIV/AIDS epidemic. Specifically, how the HIV/AIDS epidemic is affecting the need for FP and RH services.

Demographic and Health Surveys
Demographic and Health Surveys (DHS) are nationally representative household surveys with large sample sizes of between 5,000 and 30,000 households. DHS surveys provide data for a wide range of monitoring and impact evaluation indicators in the areas of HIV/AIDS, population, health, and nutrition (from DHS Web site).

Family Health International. 2003. Assessement of Voluntary Counseling and Testing Centers in Kenya. Research Triangle Park, NC: Family Health International.
This study gathered information about VCT services in Kenya in an effort to identify and to formulate programmatic options for effective integration of FP into VCT services. The study addressed the following questions (page 1):

- o Is there potential demand for FP services among VCT clients?

- Is the provision of FP services during VCT sessions acceptable to the clients, providers, and VCT center in-charges?
- What elements of contraceptive counseling and distribution are VCT services in their current form ready to offer?
- Is it feasible to provide FP services within the VCT service environment?

The study found low levels of referrals to FP services and inadequate counseling on contraceptive use.

Gichuhi, W., S. Bradley, and K. Hardee. "Provision and Use of Family Planning in the Context of HIV/AIDS in Kenya: Perspectives of Providers, Family Planning and Antenatal Care Clients, and HIV-Positive Women." Washington, D.C.: POLICY Project.
This study explores how Kenyan FP services are being implemented in light of the HIV/AIDS epidemic. Specifically, how the HIV/AIDS epidemic is affecting the need for FP and RH services.

Government of India. 2004 *National Guidelines for Implementation of Antiretroviral Therapy*. Draft. New Delhi: National AIDS Control Organization.
This draft of India's national guidelines for antiretroviral therapy includes guidance on messages for people living with HIV/AIDS. This guidance includes offering FP and advising on the different options (page 69).

Integrated Health Resources Consultants Company. 2005. "Strengthening Family Planning within PMTCT Programme in Uganda: Needs Assessment Report."
This report is a needs assessment of the FP gaps at seven PMTCT sites in Uganda. The identified gaps are intended to form the basis for interventions to strengthen FP within the Uganda PMTCT program. The assessment found several shortcomings in the FP services offered at PMTCT programs, including FP services located in different buildings than MCH services, low levels of FP knowledge among providers, lack of support to HIV-positive women, and lack of FP supplies and drugs at many health centers (pages 6 and 7).

Mekonnen, Y., S. Bradley, M. Malkin, and K. Hardee. 2004. "Country Analysis of Family Planning and HIV/AIDS: Ethiopia." Washington, D.C.: POLICY Project.
This study documents the extent to which Ethiopia has managed both its FP/RH and HIV/AIDS programs in the context of high HIV prevalence. Key informants from relevant organizations were interviewed (page iii). Two of the main findings are that FP programs are in great need of expansion and improvement and that resources are being diverted to HIV/AIDS programs.

Syacumpi, M.M., K. Liywali, M. Mbale, and M. Syacumpi. 2003. "Country Analysis of Family Planning and HIV/AIDS: Zambia," Washington, D.C.: POLICY Project.
This study documents the extent to which Zambia has managed both its FP/RH and HIV/AIDS programs in the context of high HIV prevalence. Key informants from relevant organizations were interviewed (page iv). One of the main findings is that FP

and RH programs are well integrated and receive policymaker attention; however, resources are being diverted to HIV/AIDS programs.

UNAIDS. 1999. "Knowledge is Power: Voluntary HIV Counseling and Testing in Uganda." New York: UNAIDS.
This case study of interventions used in Uganda to address and mitigate the HIV/AIDS epidemic includes a section on integration of FP services. In the clinics studied, FP services are offered along with HIV/AIDS services.

Walston, N. 2005. "Cambodia: Family Planning Programs and HIV/AIDS Services, Results of Focus Group Discussions." Washington, D.C.: POLICY Project.
This study explores how Cambodian FP services are being implemented in light of the HIV/AIDS epidemic. Specifically, how the HIV/AIDS epidemic is affecting the need for FP and RH services. Using six focus group discussions, the study found that demand for FP is increasing; however, prevailing attitudes towards FP especially condoms are still negative.

Walston, N. 2005. "Country Analysis of Family Planning and HIV/AIDS Programs Cambodia." Washington, D.C.: POLICY Project.
This report examines the present situation of both the HIV/AIDS epidemic in Cambodia and the progress of its FP program, including trends in funding, staff resources, impact of the epidemic on personnel, and actions taken by the government, NGOs, and private health sector (page v).

Wilcher, R. and E. Martin. 2004. "Integrating Family Planning and Voluntary Counseling and Testing Services in Ghana: A Rapid Programmatic Assessment." Research Triangle Park, NC: USAID, Family Health International, and Ghana Health Service.
This report attempts to show the current demand for and provision of integrated FP and HIV/AIDS services, specifically in Ghana. Through a review of existing literature and open-ended interviews with key FP and HIV/AIDS informants, the report concludes with the following two points:

- Majority of interviewees support integration
- Challenges to integration center around logistics, human resource capacity, quality of care and stigma coupled with gender dynamics

The report includes recommendations for strengthening linkages between FP and VCT.

References

Aloo-Obunga, Colette. 2003. "Country Analysis of Family Planning and HIV/AIDS: Kenya." Washington, D.C.: Futures Group, POLICY Project.

Askew, I. and M. Berer. 2003. "The Contribution of Sexual and Reproductive Health Services to the Fight Against HIV/AIDS: A Review." *Reproductive Health Matters* 11(22):51–73.

Assimwe, D., R. Kbomo, J. Matsiko, and K. Hardee. 2005. Study of the Integration of FP and VCT/PMTCT/ART Programs in Uganda. Kampala: Makerere Institute of Social Research and Washington, D.C.: Futures Group, POLICY Project.

Attawell, K. and J. Mundy. 2003. "Provision of Antiretroviral Therapy in Resource-Limited Settings: A Review of Experience up to August 2003." London: World Health Organization and UK Department for International Development.

Baek, C. and N. Rutenberg. 2005. "Addressing the Family Planning Needs of HIV-Positive PMTCT Clients: Baseline Findings from an Operations Research Study." *Horizons Research Update*. Washington, D.C.: Population Council.

Banda, Honester Nyaunde, Sarah Bradley, and Karen Hardee. 2004. "Provision and Use of Family Planning in the Context of HIV/AIDS in Zambia: Perspectives of Providers, Family Planning and Antenatal Care Clients and HIV Positive Women." Final report. Washington, D.C.: Futures Group POLICY Project. Poster at 2004 International AIDS Conference, Bangkok.

Berer, Marge. 2003. "HIV/AIDS, Sexual and Reproductive Health: Intimately Related." *Reproductive Health Matters*. 11(22):6–11.

Best, Kim. 2004. "Family Planning and the Prevention of Mother-to-Child Transmission of HIV: A Review of the Literature." Research Triangle Park, NC.: Family Health International.

Cross, H., N. Jewell, and K. Hardee. 2001. *Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs.* POLICY Occasional Paper. No. 7. Washington D.C.: Futures Group International.

Demographic and Health Surveys. <www.measuredhs.com>

Duerr, A., S. Hurst, A.P. Kourtis, N. Rutenberg, and D.J. Jamieson. 2005. "Integrating Family Planning and Prevention of Mother-to-Child HIV Transmission in Resource-Limited Settings." *The Lancet* 366: 261–263.

EngenderHealth. 2004. "Preventing HIV/AIDS Through Family Planning." New York: EngenderHealth.

Family Health International. 2003. Assessment of Voluntary Counseling and Testing Centers in Kenya. Research Triangle Park, NC: Family Health International.

Family Health International. 2004. "Network: Integrating Services." Vol. 23; No. 3. Research Triangle Park, NC.: Family Health International.

Family Health International. 2004. “Research to Practice: Underused Research Findings.” Research Triangle Park, NC: Family Health International.

Family Health International. 2005. “Contraception and HIV Factsheet” Research Triangle Park, NC: Family Health International

Family Planning and HIV Web site <www.fpandhiv.org>

Foreit, Karen, Karen Hardee, and Kokila Agarwal. 2002. “When Does it Make Sense to Consider Integrating Family Planning and STI/HIV Services?” *International Family Planning Perspectives*. 28(2):105–107.

Gichuhi, W., S. Bradley, and K. Hardee. 2004. “Provision and Use of Family Planning in the Context of HIV/AIDS in Kenya: Perspectives of Providers, Family Planning and Antenatal Care Clients, and HIV-Positive Women.” Washington, D.C.: POLICY Project.

Global HIV Prevention Working Group. 2004. “HIV Prevention in the Era of Expanded Treatment Access.” Seattle, WA: Bill and Melinda Gates Foundation

Government of India. 2004 *National Guidelines for Implementation of Antiretroviral Therapy*. Draft. New Delhi: National AIDS Control Organization.

Hamilton, Margaret. 2005. “Ensuring Contraceptive Security for HIV-Positive Women.” *POLICY Issues in Planning and Finance* No. 5. Washington, D.C.: POLICY Project.

Hardee, K, I Feranil, J Boezwinkle and B Clark. 2004. “The Policy Circle.” POLICY Working Paper No. 11. Washington, D.C.: Futures Group.

Hardee, K and K Yount. 1995. "Delivering the Reproductive Health Promise: From Rhetoric to Reality." Paper presented at the Population Association of America Meetings, San Francisco. FHI Working Paper, WP95-01.

Hardee, K., M. Rowan, L. Packer, L. Morris, K. McClure, C. Shepherd, and E. Speaker. 2005. “Assessing Intervention Strategies to Integrate Reproductive Health and HIV/AIDS Services in Jamaica.” Paper submitted for publication.

Info Project. 2004. “WHO Updates Medical Eligibility Criteria for Contraceptives.” *Info Reports.* Baltimore: Johns Hopkins Bloomberg School of Public Health.

Integrated Health Resources Consultants Company. 2005. “Strengthening Family Planning Within PMTCT Programme in Uganda: Needs Assessment Report.”

Kane, M. and T. Colton. 2005. “Integrating SRH and HIV/AIDS Services: Pathfinder International’s Experience Synergizing Health Initiatives.” Watertown, MA: Pathfinder International.

Maqweb.org

Mastro TD, de Vicenzi I. 1996. Probabilities of Sexual HIV-1 Transmission. *AIDS* 1996; 10 (Suppl. A):S75–S85.

Mastro, T.D. and D. Kitayorn. 1998. HIV Type 1 Transmission Probabilities: Estimates from Epidemiological Studies. *AIDS R Hum Retrovirus*. 1998; 14 (Suppl 3):S223–S227.

Mekonnen, Y., S. Bradley, M. Malkin, and K. Hardee. 2004. "Country Analysis of Family Planning and HIV/AIDS: Ethiopia." Washington, D.C.: POLICY Project.

Mitchell, H.S. and E. Stephens. 2004. "Contraception Choice for HIV-positive women." London, England. Sexually Transmitted Infections Journal, 2004; 80:167–173.

Newell, M.L. 2001. "Prevention of Mother-to-Child Transmission of HIV: Challenges for the Current Decade." Bulletin of the WHO; 79(12):1138–1144.

Packer, L., L. Morris, S. Taylor, J.J. McGregor, C. Leckie, K. Hardee, K. McClure, M. Rowan, C. Shepherd, and B. Clark. 2004. *Determining the Feasibility and Potential Scope of Integration of Reproductive Health (FP/MCH/STI/HIV) Services, Using Portland and St. Ann's Bay as Pilot Sites.* Kingston, Jamaica: KPMG and Washington, D.C.: Futures Group, POLICY Project.

Pathfinder International. ND. "Clinic Assessment Guide." Watertown, MA: Pathfinder International.

POLICY Project. 1998. The Policy Compendium. Washington, D.C.: POLICY Project.

POLICY Project. 2005. "Family Planning Services as a Component of Prevention of Mother-to-Child-Transmission (PMTCT) Programmes." Internal presentation. Washington, D.C.: Futures Group, POLICY Project.

Preble, E.A. and E.G. Piwoz. 2001. "Prevention of Mother-to-Child Transmission of HIV in Africa: Practical Guidance for Programs." Washington, D.C.: Academy for Educational Development.

Preble, E.A., D. Huber, and E.G. Piwoz. 2003. "Family Planning and the Prevention of Mother-to-Child Transmission of HIV: Technical and Programmatic Issues." Arlington, Virginia: Advance Africa.

Public Health Service Task Force. 2003. *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Intervention to Reduce Perinatal HIV-1 Transmission in the United States*. Washington, D.C.: U.S. Department of Health and Human Services.

Reynolds, H., B. Janowitz, R. Homan, and L. Johnson. ND. "Cost Effectiveness of Two Interventions to Avert HIV-Positive Births." Research Triangle Park: FHI.

Rutenberg, N., C. Baek, S. Kalibala, and J. Rosen. 2003. "Evaluation of United Nations-Supported Pilot Projects for the Prevention of Mother-to-Child Transmission of HIV: Overview of Findings." New York, NY: UNICEF.

Rutenberg, N. et al. 2003. "Family Planning and PMTCT Services: Examining Interrelationships, Strengthening Linkages." *Horizons Research Summary*. Washington, D.C.: Population Council.

Rutenberg, N. and C. Baek. 2004. Review of Field Experiences: Integration of Family Planning and PMTCT Services." Washington, D.C.: Population Council.
This report reviews field experiences with the integration of family planning and PMTCT services (page 4).

Rutenberg, N. and C. Baek. 2005. "Field Experiences Integrating Family Planning into Programs to Prevent Mother-to-Child Transmission of HIV." *Studies in Family Planning*. 36(3):235–245.

Shelton, J.D. and E.A. Peterson. 2004. "The Imperative for Family Planning in ART in Africa" *The Lancet* 364:1916–1917.

Stop AIDS Now, World Population Foundation, and Share-Net. 2004. "AIDS, Sex and Reproduction: Integrating HIV/AIDS and Sexual and Reproductive Health into Policies, Programmes and Services."

Strachan, Molly, Akua Kwateng-Addo, Karen Hardee, Sumi Subramaniam, Nicole Judice, and Kokila Agarwal. 2004. "An Analysis of Family Planning Content in HIV/AIDS, VCT and PMTCT Policies in 16 Countries." POLICY Working Paper No. 9. Washington, D.C.: Futures Group, POLICY Project.

Syacumpi, M.M., K. Liywali, M. Mbale, and M. Syacumpi. 2003. "Country Analysis of Family Planning and HIV/AIDS: Zambia," Washington, D.C.: POLICY Project.

Uganda Ministry of Health. 2005. "Uganda National Policy Guidelines for HIV Counselling and Testing." (Draft) June.

UNAIDS and WHO. 2002. *AIDS Epidemic Update*. Geneva: UNAIDS.

UNAIDS.1998. Mother-to-Child Transmission of HIV: UNAIDS Technical Update. Geneva: UNAIDS.

UNAIDS/UNICEF/WHO. 1998. "HIV and Infant Feeding: Guidelines for Decision-makers." Geneva: WHO.

UNAIDS. 1999. "Knowledge is Power: Voluntary HIV Counseling and Testing in Uganda." New York: UNAIDS.

UNAIDS. 2001. "Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues." New York: UNAIDS.

UNAIDS and WHO. 2004. "National Guide to Monitoring and Evaluating Programmes for the Prevention of HIV in Infants and Young Children" Geneva: WHO.

UNFPA, UNAIDS, and Family Care International. 2004. The New York Call to Commitment.

United Nations. 2004. "The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children."

USAID. 2003. "Family Planning/ HIV Integration: Technical Guidance for USAID-Supported Field Programs." Washington D.C.: United States Agency for International Development.

Walston, N. 2005. “Cambodia: Family Planning Programs and HIV/AIDS Services, Results of Focus Group Discussions.” Washington, D.C.:POLICY Project.

Walston, N. 2005. “Country Analysis of Family Planning and HIV/AIDS Programs: Cambodia.” Washington, D.C.: POLICY Project.

Wilcher, R. and E. Martin. 2004. “Integrating Family Planning and Voluntary Counseling and Testing Services in Ghana: A Rapid Programmatic Assessment.” Research Triangle Park, NC: USAID, Family Health International, and Ghana Health Service.

World Health Organization. 2000. “New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations.” WHO Technical Consultation on Behalf of UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV. October 11–13, 2000.

World Health Organization. 2002. “Increasing Access to HIV Testing and Counseling: Report of a WHO Consultation November 19–21, 2002.” Geneva: WHO.

World Health Organization. 2003. “Scaling up Antiretroviral Therapy in Resource Limited Settings: Treatment Guidelines for a Public Health Approach.” Geneva: WHO.

World Health Organization. 2004. “Emergency Scale-up of Antiretroviral Therapy in Resource-Limited Settings: Technical and Operational Recommendations to Achieve 3 by 5.” Report of the WHO/UNAIDS International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-up of Antiretroviral Therapy in Resource Limited Settings. November 18–21, 2003.